Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968157	A. BUILDING: _____ B. WING _____	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENADES BY	425 S RONALD REAGAN BLVD LONGWOOD, FL 32750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A Relicensure survey including Limited Nursing Service and Generator Monitoring were conducted on . at Serenades by . had deficiencies identified at the time of visit.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice,	A 010		

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A 010	Continued From page 1 and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . . . . . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.	A 010		

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A 010	Continued From page 2 (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and,	A 010		

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A 010	Continued From page 3 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are	A 010		

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A 010	Continued From page 4 described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility retained 1 of 2 sampled residents who exceeded the continued residency criteria in an Assisted Living Facility (ALF) by requiring total assistance with activities of daily living (ADLs) and with transferring (#1). Findings: Resident #1's record revealed a facility admission date of . An assessment form 1823, dated , indicated the resident's diagnoses included , , , and major . It also indicated the resident required assistance with all ADLs and with transferring. Observations made on at 9:52 a.m. revealed staff F and the Wellness Director both placed a under resident #1's underarms, each held on to the of the resident's pants then they lifted the resident from her wheelchair and placed her on her bed. Then home health nurse G lifted the resident's onto the bed. The resident did not participate or assist during the transfer. The Wellness Director moved the bed away from the wall then she and home health nurse G stood on opposite sides of the bed. They rolled the resident onto her left side, pulled the resident's pants down, then provided total care to the resident. A was seen on the resident's right fold. The measured approximately 4 centimeters (cm.) by 3 cm. The bed was moist and pink. A was on the left . It measured approximately 2 cm. by 2 cm. and was scabbed over. A that	A 010		

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A 010	Continued From page 5 presented as an intact, ... -filled . . . . was on the right . It measured approximately 1cm. by 1 cm. After the nurse completed the . . . . care, she and the Wellness Director redressed the resident, then both sat the resident up on the side of the bed. To transfer the resident into her wheelchair, they each placed a . . . under the resident's underarms, each grabbed hold of the . . . of the resident's pants, then they lifted her off the bed and placed her into the chair. Again, the resident did not participate or assist during the transfer. On at 10:40 a.m., staff H said resident #1 required total assistance with all of her care and with transferring. Staff H said the resident used to receive hospice services, but she began eating better, so she was discharged from services. On at 11:06 a.m.m staff A said resident #1 required total assistance with all ADLs, including transferring. He said he could transfer her on his own, but others had to have two people to do it. He said sometimes the resident reached her arms out to be transferred. He said he repositioned her on his shift when she was sliding down in her chair or every 1.5 hours. On . . . . . at 2:46 p.m., staff I said resident #1 required total assistance with all of her care and with transferring. Staff I said the resident frequently slid down in her wheelchair and had to be pulled . . . up. She said when she cared for the resident, she placed the resident into bed after lunch because the resident had . . She said she turned and repositioned the resident every two hours when in bed and said the resident was of both and	A 010		

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A 010	Continued From page 6 On [redacted] at 3:15 p.m., staff J said resident #1 leaned to one side when she was in her wheelchair. He said he repositioned the resident every two hours. He said the resident required total assistance with all care and with transferring. On [redacted] at 3:25 p.m., staff K said resident #1 required total assistance with all care and said the resident frequently slid down while in her wheelchair. Staff K said she used pillows to reposition the resident while in bed. Review of a home health recertification assessment, dated [redacted], revealed documentation that indicated resident #1 required total assistance with all ADLs and with transferring. Class III	A 010		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's	A 025		

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A 025	Continued From page 7 representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by:	A 025		

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A 025	Continued From page 8 Based on record review, observations and interviews, the facility failed to have evidence of proactive interventions that were in place to meet the needs of 1 of 2 sampled residents who exceeded Assisted living Facility residency criteria and developed three (#1). Findings: On , the Wellness Director, a License Practical Nurse, said resident #1 had open on her that she considered to be shearing from her adult brief because she would often slide down in her wheelchair. Resident #1's updated resident health assessment form 1823, dated , reflected that the health provider noted she required assistance with all of her activities of daily living (ADLs). She had diagnosis that included , , Major and The health care provider checked "No" to the question on the form that asked if the resident had , 3 or 4 . A telephone order, dated and signed by health care provider on , noted Home Health to evaluate and treat a Right Ischial . Another telephone order, dated and signed health care providers order on , noted a skilled nurse was to evaluate and treat , one on the lower /upper region, and one on the upper inner of the right . Review of the facility notes revealed the following: at 9:45 PM - open area Right Ischium, order sent to home health to evaluate	A 025		

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A 025	Continued From page 9 and treat. Staff were unable to get daughter or son on phone, so they left a message. ... at 8:35 PM - two open areas: , on Lower /Upper area and Inner/Upper of Right looked like skin injuries from shearing. First aid with a foam to protect skin was applied to the areas. ... - a home health nurse provided care to the , on the Upper /Lower ; measurements on the upper /lower were 4 cm. by 3 cm. by 0.1 cm., and was 2 cm. by 1 cm. by 0.1 cm. Review of the home health notes revealed the following: ... - Skilled nurse note documented the Left and scratch on the Left . The area was cleansed with cleaner, patted dry, skin prep was applied, and and . The on the Left was a ; Size: length 2.0 cm., Width 2.0 cm., depth 0.1 cm.; the bed was red. ... - Skilled nurse note documented the Left and scratch on the Left . The area was cleansed with cleaner, patted dry, skin prep was applied, and then and . A new was noted on the Right . The area was cleansed with cleaner, patted dry, skin prep was applied, then and and foam border . No signs of were noted. 2 on the Left was a ; Size: length- 4.0 cm., width 2.0 cm., depth 0.1 cm. 3 on the Right was a , Size: length: 4.5 cm., width 2.0 cm., depth 0.1 cm.; the bed was red. The note reflected that the resident required	A 025		

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A 025	Continued From page 10 for all transfers and ambulation. The note reflected that the resident has and required 24-hour supervision and assistance. The skilled nurse's note on reflected care to the open to the Left . The resident required two-person assistance to be transferred from recliner to wheelchair and then to bed. The resident was rolled onto the left side. The old was removed. A small amount of drainage was noted. The area was cleansed with Normal , skin prep and and were applied. " drainage is the fresh bloody that appears when skin is breached, whether from surgery, injury, or other cause. drainage is bright red and somewhat thick in consistency; some compare it to the consistency of syrup." (www. .com - retrieved on). A new was noted on the Right increase of bottom. The area was cleansed with Normal , patted dry, skin prep and and foam border was applied. A skilled nurse's note on reflected that 2 on the Left size was length 4 cm., width 2.0 cm., depth 0.1 cm.; bed Pink. The area was cleansed, patted day, and hydrocolloid was applied. 3 on the right lower size was 4.5 cm. length by 2 cm. width by dept 0.1 cm. depth, pink. The area was cleansed with cleanser, patted dry, and hydrocolloid was applied.	A 025		

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A 025	Continued From page 11 - A skilled nurse note documented that the resident was forgetful, resided in a memory care unit, and received assistance from caregivers with medications and ADLs. A skilled nurse's note on reflected care to open to the Left was done. The resident required two-person assistance to be transferred from the recliner to the wheelchair and then to the bed. The resident was rolled onto the left side, the old was removed. A small amount of drainage was noted. The was cleansed with Normal , skin prep and and were applied. There was no evidence that the facility staff had any proactive interventions in place to prevent the resident from sliding in her wheelchair, which the facility's nurse stated had caused the injuries. During an interview on at 9:45 a.m., home health nurse G said she provided care to two on resident #1's . The nurse said she did not know the of each , so she called them . She believed they possibly occurred as a result of the resident sliding down in her wheelchair or from wearing briefs. The nurse said the resident's family brought in larger briefs. Observations made on at 9:52 a.m. revealed staff F and the Wellness Director both placed a under resident #1's underarms, each held on to the of the resident's pants, then they lifted the resident from her wheelchair and placed her on her bed. After which, home health nurse G lifted the resident's onto the bed. The resident did not participate or assist during the transfer. The Wellness Director moved	A 025		

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A 025	Continued From page 12	A 025		

the bed away from the wall then she and home health nurse G stood on opposite sides of the bed. They rolled the resident onto her left side, pulled the resident's pants down, then provided total care to the resident. A was seen on the resident's Right fold. The measured approximately 4 centimeters (cm.) by 3 cm. The bed was moist and pink. A second was on the Left . It measured approximately 2 cm. by 2 cm. and was scabbed over. A third that presented as an intact, -filled was on the Right . It measured approximately 1 cm. by 1 cm. This last was not previously identified by neither the Wellness Director nor the Home Health Nurse and was no documentation in the resident's record or home health notes that indicated the existed. After the nurse completed the care, she and the Wellness Director redressed the resident, then both sat the resident up on the side of the bed. To transfer the resident into her wheelchair, they each placed a under the resident's underarms, each grabbed hold of the of the resident's pants then they lifted her off the bed and placed her into the chair. Again, the resident did not participate or assist during the transfer. The resident had a regular mattress on her bed and a cushion in her chair.

On at 10:40 a.m., staff H said resident #1 required total assistance with all of her ADLs and with transferring. Staff H said the resident used to receive hospice services, but she began eating better so she was discharged from services.

On at 11:06 a.m., staff A said resident #1 required total assistance with all ADLs and with transferring. Staff A said he could transfer the

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A 025	Continued From page 13 resident by himself, but others had to have two people to do it. He said sometimes the resident reached her arms out to be transferred. He said he repositioned her on his shift when she was sliding down in her chair or every 1.5 hours. On . . . . . at 2:46 p.m., staff I said resident #1 required total assistance with all ADLs and with transferring. Staff I said the resident frequently slid down in her wheelchair and had to be pulled . . . . up. She said when she cared for the resident, she placed the resident into bed after lunch because the resident had . . . . . . She said she turned and repositioned the resident every two hours when in bed and said the resident was of both and . . . . . . On . . . . . at 2:50 p.m. resident #1 was seen lying in her bed. She was positioned with a pillow on her left side. On . . . . . at 3:15 p.m., staff J said resident #1 leaned to one side when she was in her wheelchair. He said he repositioned the resident every two hours. He said the resident required total assistance with all ADLs and with transferring. On at 3:25 p.m., staff K said resident #1 required total assistance with all ADLs and said the resident frequently slid down while in her wheelchair. Staff K said she used pillows to reposition the resident while in bed. Review of a Home Health Recertification Assessment, dated . . . . . , revealed documentation that indicated resident #1 required total assistance with all ADLs and with transferring. The resident was total care with her	A 025		

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	AL11968157	A. BUILDING: _____ B. WING _____	01/03/2022

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A 025	Continued From page 14 ADLs which exceeded the criteria for continued residency in an Assisted Living Facility. During a telephone interview on at 2:15 p.m. with the Wellness Director present, Home Health Nurse G said she did classify and document on her assessments that the on resident #1's were , . She said once she began treating the , they presented more like shearing. She then offered to go and change the documentation to reflect the were not . During the conversation with the Home Health Nurse and the Wellness Director, the Wellness Director said that Home Health Nurse did not tell her she had documented the as , , and she was not aware that the were , . The Home Health Nurse agreed with the Wellness Director at the time. The Wellness Director was informed at the time that the facility's nurse documented in the resident's record on a telephone order on that the resident had a Right Ischial , . The Wellness Director said she was not aware of that. She said when she completed the telephone order on , she determined the to be from shearing, due to the resident sliding in her wheelchair. The record did not reflect any evidence of the proactive interventions the facility had in place for pressure relief to the resident's . The staff stated they would turn the resident, however, there was no evidence that the facility was aware that the resident had a , . The Wellness Director said the family member provided larger adult brief for the resident, however, the resident developed another	A 025		

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A 025	Continued From page 15 . . . . . that was not documented in the record by the facility or home health nurse. Class II	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary.	A 032		

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A 032	Continued From page 16 The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 1 of 3 sampled direct care staff participated in a minimum of two resident elopement drills each year (C). Findings: Review of staff C's personnel record revealed a hire date of .	A 032		

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A 032	Continued From page 17 On at 11:40 a.m., staff C said she never participated in an elopement drill since her hire date. On at 1 p.m., the administrator said staff C participated in only that drill during 2021. Review of the facility's documented elopement drills revealed staff C was listed as a participant on only one drill in 2021, which was dated . Class III	A 032		
A 093 SS=B	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the	A 093		

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A 093	Continued From page 18 residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food	A 093		

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A 093	Continued From page 19 choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for	A 093		

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A 093	Continued From page 20 obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on the menu review and interview, the facility did not maintain the dated menus for 6 months. Findings: Review of the menus provided by the dietary manager revealed the only menus available for review was for , the week ending , , and for . The facility did not maintain the dated menus for 6 months. On at 11:30 AM, the dietary manager said the menus that he provided was all that he could locate. Class	A 093		
A 160 SS=D	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include:	A 160		

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A 160	Continued From page 21 (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a [illegible]; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of [illegible]. (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with [illegible]'s [illegible] or related [illegible], a copy of all such facility	A 160		

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A 160	Continued From page 22 advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on facility record review and interview, the facility did not have the County Health	A 160		

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A 160	Continued From page 23 Department report for group care issued within the last 2 years as required. Findings: Review of the County Health Department inspection report for group care was dated . Inspections were due on and . On at 11 AM, the administrator said she was told by the Health Department that they were short staffed. She said the facility staff had called and emailed the County Health Department to inquire about the group care inspections that were required and had not received a response. Class III	A 160		